**U.S. Department of Labor**

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**Issue Date: 08 June 2005**

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In the Matter of:

**CURTIS M. KISER**
**Claimant,**

**v.** **Case No. 2003-BLA-06545**

**L & J EQUIPMENT COMPANY/**
**AMERICAN MINING INSURANCE CO.,**
**Employer/Carrier, and**

**DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,**
**Party-In-Interest.**

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Appearances:

Joseph Wolfe, Esq., Wolfe, Williams and Rutherford, Norton, VA
For Claimant

Michael F. Blair, Esq., Penn Stuart, Bristol, VA
For Employer/Carrier

Before: PAMELA LAKES WOOD
Administrative Law Judge

## DECISION AND ORDER GRANTING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. §901, *et. seq.* (hereafter "the Act") filed by Claimant Curtis Kiser ("Claimant") on May 21, 2001. The instant claim is the second claim filed by Claimant. The putative responsible operator is L & J Equipment Company ("Employer"). Claimant is receiving benefits from the Black Lung Disability Trust Fund with an entitlement date of August 1, 2001, based upon the termination date of his coal mine employment of August 31, 2001.

Part 718 of title 20 of the Code of Federal Regulations is applicable to this claim, as it was filed after March 31, 1980, and the regulations amended as of December 20, 2000 are also applicable, as this claim was filed after January 19, 2001. 20 C.F.R. §718.2. [1] In *National Mining Assn. v. Dept. of Labor,* 292 F.3d 849 (D.C. Cir. 2002), the U.S. Court of Appeals for the D.C. Circuit rejected the challenge to, and upheld, the amended regulations with the exception of several sections.[2] The Department of Labor amended the regulations on December 15, 2003 for the purpose of complying with the Court's ruling. 68 Fed. Reg. 69929 (Dec. 15, 2003).

The findings of fact and conclusions of law hereafter are based upon my analysis of the entire record, including all evidence admitted and arguments submitted by the parties. Where pertinent, I have made credibility determinations concerning the evidence.

## STATEMENT OF THE CASE

Claimant's first claim was filed on October 29, 1979. (DX 1)[3]. Claimant filed the instant claim for benefits on May 21, 2001, while he was still employed in the mines; he stopped working in the mines on August 31, 2001, however. (DX 3).

The District Director issued a September 4, 2002 Schedule for the Submission of Additional Evidence, which indicated that Claimant would be entitled to benefits based on the initial evidence and that L & J Equipment Company was the responsible operator. (DX 26). On a preliminary basis, the District Director's office concluded that the evidence indicated that the Claimant worked as a coal miner for 18 years, that Claimant has pneumoconiosis, that the Claimant's pneumoconiosis was caused at least in part by exposure to coal mine dust, that Claimant was totally disabled, and that the total disability was caused at least in part by pneumoconiosis. *Id.* On May 15, 2003, the Proposed Decision and Order issued by the District Director granted benefits to the Claimant. (DX 35). Finding that Claimant satisfied all of the requisite conditions of entitlement, the District Director ordered a payment of benefits. *Id.* Employer requested a formal hearing, and the case was transmitted to the Office of Administrative Law Judges on August 22, 2003 for a hearing.

A hearing in the above-captioned matter was held on March 2, 2004 in Abingdon, Virginia. Claimant was the only witness who offered testimony, and he was a credible witness. In addition, Claimant was deposed on July 22, 2002. (DX 31).

At the hearing, Director's Exhibits 1 through 47 ("DX 1" through "DX 47") were admitted into evidence. (Tr. at 5). Claimant's Exhibit 1 ("CX 1"), and Employer's Exhibits 1 through 5 ("EX 1" through "EX 5") were also admitted into evidence. (Transcript of Hearing ("Tr.") 8-9; 33-34). At the conclusion of the proceedings, the record was kept open for 30 days

[1] Section and part references appearing herein are to Title 20 of the Code of Federal Regulations unless otherwise indicated.

[2] Several sections were found to be impermissibly retroactive and one which attempted to effect an unauthorized cost shifting was not upheld by the court.

[3] The prior file could not be located by the District Director's Office. *See* DX1. However, the computer database showed the date the first claim was filed. My prior Orders of June 24, 2004 and October 5, 2004 discuss the efforts that were made to locate the missing file (which was presumably destroyed) and the Orders allowed the parties to supplement the record with evidence from the 1979 claim.

in order to allow Employer the opportunity to have the September 3, 2003 x-ray re-read, and the period could be extended by the stipulation of the parties. (Tr. 33, 35). Pending resolution of that matter, Claimant's Exhibit 2 ("CX 2"), which included both the reading of that x-ray by Dr. Patel and Dr. Rasmussen's September 3, 2003 examination report, was not formally admitted. In addition, Claimant was allowed to provide rehabilitative evidence relating to the pulmonary function studies dated September 3, 2003 [mistranscribed as 2000]. (Tr. 35-36). Thereafter, the parties had 45 days from the closing of the record to submit closing arguments. (Tr. 36). However, this matter was delayed due to difficulty in locating the September 3, 2003 x-ray and the missing 1979 claim.

By Order of October 5, 2004, upon receipt of advice that the Employer had located the September 3, 2003 film, I clarified that the record would be kept open until December 6, 2004 for submission of a single reading of the September 3, 2003 x-ray by the Employer and that Claimant would also be permitted to submit rehabilitative evidence from the same expert, Dr. Patel. Thereafter, under cover letter of October 7, 2004, Employer submitted the August 30, 2004 reading of the September 3, 2003 x-ray, which has been marked as Employer's Exhibit 6 ("EX 6"). No rehabilitation evidence was submitted by Claimant. CX 2 and EX 6 are now formally admitted into evidence and the record is now closed. **SO ORDERED.**

On March 2, 2005, I granted a joint request submitted by Employer to extend the filing deadline to March 11, 2005, and later a request by Claimant was also granted to extend the filing deadline for closing briefs until April 15, 2005.

Employer, in his response to Claimant's March 15, 2005 request for an extension to file closing briefs, objected to the Claimant's Evidence Summary Form, which designated a January 16, 2004 biopsy report by Dr. David R. Soike as one of Claimant's exhibits. This evidence was not in the record and not admitted during the hearing. As stated in my Order of March 24, 2005, the reference to Dr. Soike's report in the Claimant's Evidence Summary Form is **STRICKEN**.

On April 19, 2005, Employer submitted its closing brief, and Claimant submitted a closing brief on April 22, 2005.

## FINDINGS OF FACT AND CONCLUSIONS OF LAW

### Issues/Stipulations

As clarified at the hearing, the issues before me are the existence of pneumoconiosis, its causal relationship to coal mine employment, total disability, total disability causation[4], length of coal mine employment beyond 15 years, and subsequent claims. (DX 45; Tr. 7). Additional issues were listed for appellate purposes. *Id.*

Employer stipulated to at least 15 years of coal mine employment. (Tr. 7).

[4] At the hearing, Employer withdrew the issues of whether Claimant was a miner, whether he was so employed post 1969, and whether he established dependency of one dependent for augmentation purposes. (Tr. 7).

## Medical Evidence

The medical evidence submitted in connection with this claim consists of the following:

(1) An examination report for the Department of Labor examination of the Claimant conducted by D.L. Rasmussen, M.D. on August 16, 2001, together with the x-ray findings (by Manu Patel, M.D., with a quality reading by Shiv Navani, M.D.), pulmonary function testing, arterial blood gases, and electrocardiogram for that exam (DX 10, DX 11) (DOL);

(2) A rereading of the August 16, 2001 x-ray by William W. Scott, Jr., M.D. (DX 33) (Employer's Rebuttal);

(3) Readings of a May 9, 2003 x-ray by Kathleen A. Deponte, M.D. and of a September 3, 2003 x-ray by Manu Patel, M.D. (CX 1, CX 2) (Claimant's Initial);

(4) Re-Readings of May 9, 2003 and September 3, 2003 x-ray by William H. Scott, Jr., M.D. (EX 4, EX 6) (Employer's Rebuttal);

(5) Readings of a September 30, 2002 x-ray by Dennis Halbert, M.D. and William W. Scott, Jr., M.D., and the reading of a November 22, 2002 x-ray by Jerome F. Wiot, M.D. (DX 32, EX 1, 3) (Employer's Initial);[5]

(6) An examination report by David M. Rosenberg, M.D. on September 30, 2002, together with the x-ray readings (by Dr. Rosenberg and Dr. Halbert), pulmonary function testing, arterial blood gases, and electrocardiogram for that exam (DX 32) (Employer's Initial);[6]

(7) An examination report by Gregory Fino, M.D. on November 22, 2002, together with the x-ray reading (by Dr. Wiot), pulmonary function testing (with Dr. Mettu's appended report), arterial blood gases, and electrocardiogram for that exam (EX 1) (Employer's Initial);

(8) An examination report by Dr. Rasmussen on September 3, 2003, together with the x-ray reading (by Dr. Patel), pulmonary function testing, arterial blood gases, and electrocardiogram for that exam. (CX 2) (Claimant's Initial);

(9) An assessment of the September 3, 2003 pulmonary function test by Sarah Long, M.D. (EX 5) (Employer's Rebuttal);

(10) An April 24, 2003 interpretation of a November 22, 2002 CT Scan by Dr. Rosenberg (EX 2);[7]

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[5] As indicated below, Dr. Scott's reading is in excess of the evidentiary limitations in the new regulations and is being stricken.

[6] Dr. Rosenberg's x-ray reading is also in excess of the evidentiary limitations and is being stricken, as discussed below.

[7] Dr. Fino's interpretation of that CT scan appears in his examination report of the same date.

(11) A medical record containing pulmonary function studies dated June 11, 1987 from St. Mary's Hospital (DX 34);

(12) A medical record containing an x-ray report by Dr. M.R. Ramakrishnan, M.D. dated April 1, 1985 from Southwest Virginia Community Health Services (DX 34);

(13) A medical record containing pulmonary function test results from Norton Community Hospital dated January 2, 2001 (DX 34);

(14) A letter dated December 28, 2000 from Dr. Gregory R. Wagner concerning the interpretation of a December 28, 2000 x-ray (DX 17).[8]

## Background and Employment History

Claimant was seventy five years old and married to his wife, Neva, of 52 years at the time of the hearing. (Tr. 13-16).

Claimant testified that he was last employed with L & J Equipment on August 31, 2001, when he was 72 years old. (Tr. 14-15). He worked as an outside man at the coal mines. *Id.* at 15. As an outside man, he shoveled around the drives and stockpiles where the coal comes out of the mine. *Id.* at 21. He kept the coal together for pickup by the trucks. *Id.* He also swept out the bathhouse, pumped water in the tank, and answered the phone. *Id.* He returned back to work when he was 70 years old after being off from work since 1988, because he and his wife did not have health care coverage. *Id.* at 15.

He stated that he worked in the coal mines since age eighteen, in approximately 1947 (when he started working for R J John Coal Company, Frank Hardway McCoy and Linda Coal Company), but he took three years off from 1950 to 1953 to serve in the U.S. Army. (Tr. 16). He has worked for various coal mine employers, including Clinchfield Coal Company, Westmoreland, Clarence Phillips, and various truck mines *Id.* at 16-17. He left coal mine work from the years of 1962 until 1975 and moved to Maryland to work in a foundry. *Id.* at 17. At the foundry, he worked for six years as a molder, grinding the insides of church bells. (Tr. 26, 29). To make the bells, he used sand and charcoal. (Tr. 31-32). He worked as a truck mechanic after he left the foundry, for about five or six years, and his work included working on brakes. (Tr. 27). Thereafter, he returned to coal mining work for Pittson Company in 1975, Rocky Coal Company from 1978 to 1986, Pennington Coal in 1978, B & B Mining in 1980, and Mack Coal Company. (Tr. 17-18.) In 1998, he began employment with L & J Equipment Company and he testified that he continued to work there until the mine closed down the last of October.[9] *Id.* at 18. He stated that overall he has 26 years of underground and 2 years of above ground (working as an outside man for a deep mine) mining experience. *Id.* at 19; DX 31 at 9. Employer

[8] Dr. Wagner's letter is also being stricken, as discussed below.

[9] Earlier, Claimant had testified that he terminated his employment at the end of August 2001 instead of October 2001. At his deposition, Claimant testified that his last pay period was the one that ended in August of 2001. (DX 31 at p. 9). I find the August 2001 date to be more reliable as it has been referenced elsewhere in the record (e.g., DX 25, Operator Response; DX 26, Evidence Submission Schedule)

stipulated to at least 15 years of coal mine employment. (Tr. at 7). After reviewing the social security records, I find that Claimant has established 26 years of coal mine employment.

Claimant stated that he is unable to return to the mines and perform his last employment due to short windedness. (Tr. 20). He did not have difficulty doing his job until he was hospitalized for pneumonia on two occasions in 2001 (one of which was for a one week period) while he was still working. *Id.; see also* CX 2. Claimant testified that he currently experiences shortness of breath while walking; he can only climb four steps, and he is unable to even carry groceries up the steps. (Tr. 20).

Claimant testified that he was a cigarette smoker while in the Military Service, and he could not remember exactly how long he was a smoker. (Tr. at 28). Mr. Kiser reported to the DOL examiner that he began smoking at age 18 in 1950 and continued to smoke one half of a pack of cigarettes for three years until 1953.[10] (DX 11). I find that two packs years is a reasonable estimate.

## Discussion

### Evidentiary Limitations

My consideration of the medical evidence is limited under the regulations, which apply evidentiary limitations to all claims filed after January 19, 2001. 20 C.F.R. §725.414. Section 725.414, in conjunction with Section 725.456(b)(1), sets limits on the amount of specific types of medical evidence that the parties can submit into the record. *Dempsey v. Sewell Coal Co.,* 21 BLR --, BRB No. 03-0615 BLA (June 28, 2004) (en banc) (slip op. at 3)*, citing* 20 C.F.R. §§725.414; 725.456(b)(1). Under section 725.414, the claimant and the responsible operator may each "submit, in support of its affirmative case, no more than two chest X-ray interpretations, the results of no more than two pulmonary function tests, the results of no more than two arterial blood gas studies, no more than one report of an autopsy, no more than one report of each biopsy, and no more than two medical reports." *Id., citing* 20 C.F.R. §725.414(a)(2)(i),(a)(3)(i). In rebuttal of the case presented by the opposing party, each party may submit "no more than one physician's interpretation of each chest X-ray, pulmonary function test, arterial blood gas study, autopsy or biopsy submitted by" the opposing party "and by the Director pursuant to §725.406." *Id., citing* 20 C.F.R. §725.414(a)(2)(ii), (a)(3)(ii). Following rebuttal, each party may submit "an additional statement from the physician who originally interpreted the chest X-ray or administered the objective testing," and, where a medical report is undermined by rebuttal evidence, "an additional statement from the physician who prepared the medical report explaining his conclusion in light of the rebuttal evidence." *Id.* "Notwithstanding the limitations" of section 725.414(a)(2),(a)(3), "any record of a miner's hospitalization for a respiratory or pulmonary or related disease, or medical treatment for a respiratory or pulmonary or related disease, may be received into evidence." *Id., citing* 20 C.F.R. §725.414(a)(4). Medical evidence that exceeds the limitations of Section 725.414 "shall not be admitted into the hearing record in the absence of good cause." *Id., citing* 20 C.F.R.

[10] Dr. Fino reports that Claimant began smoking in 1954 and stopped in 1979. (EX 1). I reject this conflicting history in view of Claimant's otherwise consistent reporting that he smoked when he was in the military (from 1950 to 1953).

§725.456(b)(1). The parties cannot waive the evidentiary limitations, which are mandatory and therefore not subject to waiver. *Phillips v. Westmoreland Coal Co.,* ALJ No. 2002-BLA-05289, BRB No. 04-0379 BLA (BRB Jan. 27, 2005) (unpub.) (slip op. at 6).

With the exception of x-ray readings, all of the evidence is in compliance with the numerical limitations. Employer submitted three x-ray readings for the September 30, 2002 x-ray. In his report relating to the September 30, 2002 examination, Dr. Rosenberg referenced the x-ray reading by Dr. Dennis Halbert while also referring to his own interpretation of the same x-ray dated September 30, 2002. Both x-ray readings were submitted with the medical report. In addition, Employer submitted the December 30, 2003 rereading by William W. Scott, Jr. of the September 30, 2002 x-ray. Although Dr. Scott's rereading was listed as rebuttal evidence, it does not qualify as such because the only other readings of that x-ray were submitted by the Employer as its initial evidence. Employer is only allowed to submit one reading of the September 30, 2002 x-ray, because Employer also submitted the November 22, 2002 x-ray reading by Dr. Wiot as x-ray evidence.[11] Employer designated Dr. Halbert's reading of the September 20, 2002 x-ray and Dr. Wiot's reading of the November 22, 2002 x-ray as the two initial x-ray readings allowed under the evidentiary limitations for the Employer. Employer's belated attempt in its Written Closing Argument of April 15, 2005 to substitute Dr. Scott's interpretation for Dr. Halbert's is **DENIED** for the reasons discussed below (in the section related to the x-ray evidence.) Therefore, the x-ray readings by Dr. Rosenberg and Dr. Scott of the September 30, 2002 x-ray exceed the evidentiary limitations and the x-rays and any references thereto are **STRICKEN**. **SO ORDERED.**

An additional x-ray reading purportedly by Dr. Gregory R. Wagner relating to a December 28, 2000 x-ray was also mentioned by the Department of Labor as being one of Claimant's initial exhibits. (DX 35). However, that x-ray reading was not designated by the Claimant before me. Moreover, the reading itself is not of record, although a March 7, 2001 letter from Dr. Wagner referencing a reading of that x-ray by unspecified "NIOSH-approved physicians" is of record. (DX 17). Dr. Wagner's narrative lacks sufficient information, in addition to exceeding the evidentiary limitations, and it is **STRICKEN. SO ORDERED.**

In addition to the above, both Dr. Rosenberg's and Dr. Fino's reports refer to inadmissible evidence. Nevertheless, they will still be considered as evidence to the extent the findings in the report are premised upon other admissible evidence. According to §718.414(a)(3)(i):

> any chest x-ray interpretations, pulmonary function test results, blood gas studies, autopsy report, biopsy report, and physicians' opinions that appear in a medical report must each be admissible under this paragraph or paragraph (a)(4) of this section.

As noted in *Dempsey,* the regulations do not specify what is to be done with a medical report or testimony that references an inadmissible x-ray. *Dempsey v. Sewell Coal Co.,* 21 BLR --, BRB No. 03-0615 BLA (June 28, 2004) (en banc). Further, the Board held that the administrative law

[11] Dr. Wiot's interpretation was returned by the district director as exceeding the evidentiary limitations (DX 44) but was resubmitted as part of EX 1 at the hearing in this matter. It was also designated by Employer as one of its two initial x-ray readings.

judge did not abuse his discretion in declining to consider a physician's opinion which he found was "inextricably tied" to an inadmissible x-ray reading. *Id.* at 15-16. I do not find that Dr. Rosenberg's medical opinion is inextricably tied to the excluded evidence (including his own x-ray interpretation) as his conclusions were based on other factors, such as Dr. Halbert's x-ray interpretation that was admissible. *See* 20 C.F.R. §725.414(a)(2)(ii). Similarly, Dr. Fino's report, while summarizing some findings that are inadmissible, including his own x-ray reading, is also based upon admissible evidence, such as Dr. Wiot's reading. Therefore, the medical reports of Drs. Rosenberg and Fino will not be excluded from consideration. However, when considering their opinions, I will not consider any discussion of inadmissible evidence.

**Subsequent Claims Analysis**

The instant case is a subsequent claim, because it was filed more than one year after the first denial of benefits in 1980.[12] *See* §725.309(d). Previously, such a claim would be denied based upon the prior denial unless the Claimant could establish a material change in conditions. *See* 20 C.F.R. §725.309(d). The Fourth Circuit Court of Appeals held that a Claimant must prove, by a preponderance of the evidence developed subsequent to the denial of the prior claim, at least one of the elements adjudicated against him in the prior denial. *Lisa Lee Mines v. Director, OWCP*, 86 F.3d 1358 (4th Cir. 1996) (en banc).

The amended regulations have replaced the material-change-in-conditions standard with the following standard:

> (d) If a claimant files a claim under this part more than one year after the effective date of a final order denying a claim previously filed by the claimant under this part (see §725.502(a)(2)), the later claim shall be considered a subsequent claim for benefits. **A subsequent claim** shall be processed and adjudicated in accordance with the provisions of subparts E and F of this part, except that the claim **shall be denied unless the claimant demonstrates that one of the applicable conditions of entitlement** (see §§725.202(d) (miner), 725.212 (spouse), 725.218 (child), and 725.222 (parent, brother, or sister)) **has changed since the date upon which the order denying the prior claim became final.**[13] The applicability of this paragraph may be waived by the operator or fund, as appropriate. The following additional rules shall apply to the adjudication of a subsequent claim:
>
> (1) Any evidence submitted in connection with any prior claim shall be made a part of the record in the subsequent claim, provided that it was not excluded in the adjudication of the prior claim.
>
> (2) For purposes of this section, **the applicable conditions of entitlement shall be limited to those conditions upon which the prior denial was based.** For

[12] The computer print out stated that the claim was filed on 10/29/79. The last action date under adjudication was 10/01/80. (DX1) Therefore, I will assume that the later date was the date of the denial.

[13] For a miner, the conditions of entitlement include whether the individual (1) is a miner as defined in the section; (2) has met the requirements for entitlement to benefits by establishing pneumoconiosis, its causal relationship to coal mine employment, total disability, and contribution by the pneumoconiosis to the total disability; and (3) has filed a claim for benefits in accordance with this part. 20 C.F.R. §725.202(d) *Conditions of entitlement: miner.*

example, if the claim was denied solely on the basis that the individual was not a miner, the subsequent claim must be denied unless the individual worked as miner following the prior denial. Similarly, if the claim was denied because the miner did not meet one or more of the eligibility criteria contained in part 718 of this subchapter, the subsequent claim must be denied unless the miner meets at least one of the criteria that he or she did not meet previously.

(3) **If the applicable condition(s) of entitlement relate to the miner's physical condition, the subsequent claim may be approved only if new evidence submitted in connection with the subsequent claim establishes at least one applicable condition of entitlement.** . .

(4) If the claimant demonstrates a change in one of the applicable conditions of entitlement, no findings made in connection with the prior claim, except those based on a party's failure to contest an issue (see § 725.463), shall be binding on any party in the adjudication of the subsequent claim. However, any stipulation made by any party in connection with the prior claim shall be binding on that party in the adjudication of the subsequent claim. . . .[Emphasis added.]

20 C.F.R. § 725.309(d) (2003). Thus, it is necessary to look at the new evidence relating to each medical condition of entitlement to determine whether it establishes that condition of entitlement.

Despite an extensive search, the prior claim in this case could not be located, and thus I am unable to determine the basis for the prior denial of benefits in order to determine where to begin my analysis in this subsequent claim. In this regard, there is no evidence of record from the previous claim and the previous decision on that claim is not of record. However, inasmuch as the claim was filed in 1979 and denied in 1980, when the Claimant was still working in the coal mines, the claim may have been denied on that basis. Claimant is no longer working in the mines and has arguably satisfied a condition of entitlement upon which the prior denial was premised. In any event, in order to prevail, Claimant would have to establish each of the elements of entitlement. Therefore, I will proceed to consideration of the merits of this claim.

**Merits of the Claim**

To prevail in a claim for Black Lung benefits, a claimant must establish that he or she suffers from pneumoconiosis; that the pneumoconiosis arose out of coal mine employment; that he or she is totally disabled, as defined in section 718.204; and that the total disability is due to pneumoconiosis. 20 C.F.R. §§718.202 to 718.204. The Supreme Court has made it clear that the burden of proof in a black lung claim lies with the claimant, and if the evidence is evenly balanced, the claimant must lose. *Director, OWCP v. Greenwich Collieries*, 512 U.S. 267, 281 (1994). In *Director, OWCP v. Greenwich Collieries*, the Court invalidated the "true doubt" rule, which gave the benefit of the doubt to claimants. *See Id.* Thus, in order to prevail in a black lung case, a claimant must establish each element by a preponderance of the evidence.

***Existence of Pneumoconiosis***

The regulations (both in their original form and as revised effective January 19, 2001) provide several means of establishing the existence of pneumoconiosis: (1) a chest x-ray meeting criteria set forth in 20 C.F.R. §718.102, and in the event of conflicting x-ray reports, consideration is to be given to the radiological qualifications of the persons interpreting x-ray reports; (2) a biopsy or autopsy conducted and reported in compliance with 20 C.F.R. §718.106; (3) application of the irrebuttable presumption for "complicated pneumoconiosis" set forth in 20 C.F.R. §718.304 (or two other presumptions set forth in §718.305 and §718.306); or (4) a determination of the existence of pneumoconiosis as defined in §718.201 made by a physician exercising sound judgment, based upon objective medical evidence and supported by a reasoned medical opinion. 20 C.F.R. §718.202(a) (1)-(4). Under section 718.107, other medical evidence, and specifically the results of medically acceptable tests and procedures which tend to demonstrate the presence or absence of pneumoconiosis, may be submitted and considered. The United States Court of Appeals for the Fourth Circuit has held that all of the evidence from section 718.202 should be weighed together in determining whether a miner suffers from pneumoconiosis. *See Island Creek Coal Co. v. Compton*, 211 F.3d 203, 208-209 (4th Cir. 2000). *But cf. Furgerson v. Jericol Mining, Inc.*, 22 B.L.R. 1-216 ( 2002) (en banc) (noting "the Sixth Circuit has often approved the independent application of the subsections of Section 718.202(a) to determine whether claimant has established the existence of pneumoconiosis.")

Because pneumoconiosis is a progressive and irreversible disease, it may be appropriate to accord greater weight to the most recent evidence of record, especially where a significant amount of time separates newer evidence from that evidence which is older. *Clark v. Karst-Robbins Coal Co*., 12 B.L.R. 1-149 (1989) (en banc); *Casella v. Kaiser Steel Corp*., 9 B.L.R. 1-131 (1986).

In the recent amendments to the regulations, the definition of pneumoconiosis in section 718.201 has been amended to provide for "clinical" and "legal" pneumoconiosis and to acknowledge the latency and progressiveness of the disease. Legal pneumoconiosis is defined as "any chronic lung disease arising out of coal mine employment." 20 C.F.R. §718.201(a). The regulation further indicates that a lung disease arising out of coal mine employment includes "any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment." 20 C.F.R. §718.201(b).

X-Ray Evidence. Claimant failed to establish pneumoconiosis by a preponderance of the x-ray evidence submitted in connection with this claim. In this regard, the x-ray evidence that is in compliance with the regulatory (ILO) criteria and the evidentiary limitations consists of the following:

| Exhibit No. | Date of X-ray/ Reading | Physician/ Qualifications | Interpretations |
|---|---|---|---|
| DX 15 | **August 16, 2001**/ August 27, 2001 | Manu Patel B-Reader & BCR | Positive for pneumoconiosis; s/p; all six zones; 2/2; large A opacities; 1.0 and 2.0 cm. opacities of CWP or neoplasm; quality (2). |
| DX 16 | August 16, 2001/ November 17, 2001 | Shiv Navani B-Reader & BCR | Quality only (3). |
| DX 33 | August 16, 2001/ August 23, 2002 | William W. Scott, Jr. B-reader & BCR | Negative for pneumoconiosis; Bullae, emphysema, probable calcified granulomata; possible minimal nonspecific linear interstitial fibrosis; quality (2). |
| DX 32 | **September 30, 2002** Same | Dennis Halbert B-Reader & BCR | Positive for pneumoconiosis; s/t; lower 4 zones; 1/1; "no evidence of CWP"; possible mass, irregular opacities consistent with pneumoconioses such as asbestosis; quality (1). |
| EX 1 | **November 22, 2002**/ December 12, 2002 | Jerome F. Wiot B-Reader & BCR | Negative for pneumoconiosis; bullae, emphysema; quality (2). |
| CX 1 | **May 9, 2003**/ June 6, 2003 | Kathleen A. Deponte B-Reader & BCR | Positive for pneumoconiosis; s/s; all six zones; 2/2; quality (1). |

| Exhibit No. | Date of X-ray/ Reading | Physician/ Qualifications | Interpretations |
|---|---|---|---|
| EX 4 | May 9, 2003/ June 6, 2004 | William W. Scott, Jr. B-Reader & BCR | Negative for pneumoconiosis; hyperinflation lungs compatible with emphysema; ? tb; ill defined scars/nodules, cannot exclude neoplasm or active infection; quality (2). |
| CX 2 | **September 3, 2003** Same | Manu Patel B-Reader & BCR | Positive for pneumoconiosis; s/s; all six zones; 2/2; emphysema, bullae, enlarged hilar nodes; occ. macronodules consistent w/ coal dust granulomas; quality (1). |
| EX 6 | September 3, 2003/ August 30, 2004 | William W. Scott, Jr. B-Reader & BCR | Negative for pneumoconiosis; hyperinflation lungs compatible with emphysema; bullous emphysema; linear scars; quality (1). . |

As noted in the table above, Dr. Halbert found opacities consistent with pneumoconiosis of some type (such as asbestosis) but no CWP [coal worker's pneumoconiosis.] Nevertheless, his reading may be deemed positive for pneumoconiosis because the regulations do not limit the diseases covered to CWP and specifically include silicosis. It is enough that opacities consistent with pneumoconiosis are present on the x-rays. *See Connor v. Peabody Coal Co.,* 22 B.L.R. 1-1 (1999) (en banc) (proper for ALJ to consider x-ray interpretation as positive for pneumoconiosis without considering comment that condition was not CWP, as that merely addresses the source.)

In Employer's Closing Argument of April 15, 2005 (at page 4), Employer sought to substitute Dr. Scott's negative interpretation of the September 30, 2002 film (EX 3) for Dr. Halbert's positive interpretation (DX 32). However, I will not allow such a substitution at this late date as Claimant has reasonably relied upon Employer's prior designation and Employer has made no showing of good cause for amending its designation over one year after the hearing in this matter. *See Dempsey v. Sewell Coal Co.,* 23 B.L.R. 1-47 (2004) (en banc) (no abuse of discretion when ALJ refused employer's request to substitute report at hearing.)

In determining the existence of pneumoconiosis based on chest x-ray evidence, "where two or more X-ray reports are in conflict, in evaluating such X-ray reports consideration shall be

given to the radiological qualifications of the physicians interpreting such X-rays." 20 C.F.R. §718.202(a) (1). The Board has held that it is proper to accord greater weight to the interpretation of a B-reader or board-certified radiologist over that of a physician without these specialized qualifications. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211 (1985); *Allen v. Riley Hall Coal Co.*, 6 B.L.R. 1-376 (1983). Moreover, an interpretation by a dually-qualified B-reader and board-certified radiologist may be accorded greater weight than that of a B-reader. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211 (1985); *Sheckler v. Clinchfield Coal Co.*, 7 B.L.R. 1-128 (1984).

The x-ray evidence is conflicting. In reviewing all of the x-ray evidence, I note that there are four positive x-ray readings and four to the contrary. There were five x-rays, one of which (September 30, 2002) was interpreted as positive; one of which (November 22, 2002) was interpreted as negative; and the remainder of which (August 16, 2001; May 9, 2003; and September 3, 2003) were interpreted as positive by one reader and negative by another reader. All of the physicians are equally qualified as B-readers and board certified radiologists, and therefore it is not possible to accord greater weight to certain x-ray readings based upon credentials. Furthermore, the later evidence rule, which gives greater weight to the most recent x-ray study of record due to the progressive nature of pneumoconiosis, does not help to distinguish the x-ray studies, because the most recent x-ray study dated September 3, 2003 was interpreted as negative by Dr. Scott and positive by Dr. Patel, who are equally qualified as B-readers and board certified radiologists. *Clark v. Karst-Robbins Coal Co*., 12 B.L.R. 1-149 (1989) (en banc). It is worth noting that even the supposedly negative x-ray readings noted abnormal x-ray findings but disagreed that they were consistent with any form of pneumoconiosis. However, it is the Claimant's burden of proof, and thus Claimant cannot prevail under 20 C.F.R. §718.202(a)(1). Nevertheless, in view of the split among readers, reliance by a physician upon an x-ray reading will not be a basis for discrediting that opinion, even though the x-ray evidence does not satisfy the requirements of subsection (a)(1).

Autopsy or Biopsy Evidence. As there is no autopsy or biopsy evidence of record, Claimant has failed to establish the presence of the disease under 20 C.F.R. §718.202(a)(2).

Complicated Pneumoconiosis and Other Presumptions. A finding of opacities of a size that would qualify as "complicated pneumoconiosis" under 20 C.F.R. §718.304 results in an irrebuttable presumption of total disability. There is evidence of complicated pneumoconiosis in the x-ray interpretation dated August 16, 2001 by Dr. Patel. However, of the eight x-ray interpretations, only one x-ray reading found large opacities consistent with complicated pneumoconiosis. Further, the same reader, Dr. Patel, did not find complicated pneumoconiosis on a later (September 3, 2003) x-ray. Therefore, the preponderance of the evidence does not support this finding, and section 718.304 presumption is inapplicable. The additional presumptions described in section 718.202(a)(3), which are set forth in 20 C.F.R. §718.305 and 20 C.F.R. §718.306 are also inapplicable, inter alia, because they do not apply to claims filed after January 1, 1982 or June 30, 1982, respectively. Further, section 718.306 does not apply, because the miner did not die on or before March 1, 1978. Thus, Claimant has failed to establish the presence of pneumoconiosis under 20 C.F.R. §718.202(a)(3).

Medical Opinions on Pneumoconiosis. However, I find that the medical opinion evidence does, by a preponderance of the evidence, establish pneumoconiosis. The following physicians submitted medical opinions on the issue of the existence of pneumoconiosis:

- Dr. Rasmussen, who conducted the Department of Labor examination on August 16, 2001 and who also conducted an examination on behalf of Claimant on September 3, 2003;
- Dr. Rosenberg, who examined the Claimant on behalf of the Employer on September 30, 2002, and who prepared an addendum based upon his review of a November 22, 2002 CT scan;
- Dr. Fino, who examined the Claimant on behalf of the Employer on November 22, 2002.

**(1) D. L. Rasmussen**, **M.D**., examined the Claimant on August 16, 2001 upon the request of the Department of Labor. The Claimant's coal mine employment, medical and family history, and present physical condition was summarized in the report. Claimant reported wheezing, sputum and dyspnea, and coughing, and that he smoked one half pack of cigarettes daily from 1950 to 1953. The diagnostic testing revealed that the chest x-ray was positive for pneumoconiosis; the ventilatory study was normal; the arterial blood gas showed marked impairment in oxygen transfer. EKG was within normal limits. Claimant was diagnosed with a possible case of complicated pneumoconiosis and chronic bronchitis; the cause of both diagnoses was coal mine dust exposure from 37 years of coal mine experience. He also concluded that Claimant had a marked loss of lung function and does not retain the capacity to perform his last coal mining job. Further, the report stated that the only known risk factor was coal mine dust exposure, although the possibility of a right and left shunt is not excluded. (DX 10).

Dr. Rasmussen also provided a supplemental medical report. In this report, he summarized the Claimant's current physical condition, medical history, family history, and occupational history. The physical examination revealed normal chest expansion and diaphragmatic excursions. The breath sounds were moderately reduced with bilateral fine inspiratory crackles, and there was some prolongation of the expiratory phase with forced respirations. Heart tones were normal with no murmurs, gallops, or clicks.

The ventilatory studies were normal, but the arterial blood gas study revealed marked impairment in resting oxygen transfer. Dr. Rasmussen indicated Claimant's baseline blood gases were PCO2 of 28 and PO2 of 59; however after seven minutes of exercise, the PCO2 was 29 and PO2 was 55, showing impairment on light exercise.[14] He concluded that this degree of impairment showed that Claimant was totally disabled for any significant gainful employment. The report stated that Claimant has a significant history of exposure to coal mine dust, and the x-ray changes are consistent with pneumoconiosis, possibly complicated pneumoconiosis. He stated that it was medically reasonable to conclude that Claimant had CWP (coal worker's pneumoconiosis) which arose from his coal mine employment. Although the possibility of a

[14] The baseline blood gases were taken on the treadmill before exercise began; they differ from the resting blood gases taken before, which were PCO2 25 and PO2 52. (DX 12; *compare* DX 11, 14). This matter is discussed further under the section of this decision relating to total disability.

resting right to left shunt[15] was not entirely excluded, Dr. Rasmussen determined that his coal mine dust exposures remained the only known cause of Claimant's impairment. (DX 11).

**(2) Dr. Rasmussen** conducted another examination of the Claimant on September 3, 2003. The report summarized Claimant's present condition, past medical history, family history, and occupational history. Claimant reported smoking about three-fourth packs of cigarettes from 1950 to 1954. Dr. Rasmussen provided a more detailed, more accurate occupational history and assumed 23 years of coal mine employment instead of the 37 years he listed in his previous report.

The chest examination revealed normal expansions and diaphragmatic excursions. Breath sounds were reduced on the right, and the sounds were moderately to markedly reduced on the left with fine crackles and moderate crackles at the bases. There was prolonged expiratory phase with force respirations, and the heart tones were reduced. Dr. Rasmussen heard no murmurs, gallops, or clicks in the heart tones.

Dr. Rasmussen also summarized the testing results. The chest x-ray interpreted by Dr. Manu Patel was positive with s/s opacities of 2/2 profusion in all zones. The electrocardiogram was within normal limits, and ventilatory function studies were within normal limits with minimal improvement after bronchodilator therapy. The arterial blood gas studies revealed resting hypoxemia, and after six minutes of the treadmill exercise study Claimant experienced very marked impairment in oxygen transfer and he was at least moderately hypoxic. The single breath carbon monoxide diffusing capacity was markedly reduced.

Dr. Rasmussen interpreted these findings as showing a very marked loss of lung function and he concluded that Claimant does not have the pulmonary capacity to perform his last regular coal mine job. Further, he concluded that the x-ray changes were consistent with CWP. Also based on the significant history of coal dust exposure, it was medically reasonable that the CWP arose from his coal mine employment.

Dr. Rasmussen stated that the only known risk factor for the Claimant's disabling lung disease was his coal mine dust exposure. Further, the pattern of marked impairment in oxygen transfer, decreased diffusing capacity, and marked exercise hypoxia further supports that Claimant's condition is the effect of coal mine dust exposure. In addition, he found that progressive impairment of Claimant's pulmonary functions was present since the August 16, 2001 examination. (CX 2).

**(3) David M. Rosenberg, M.D.,** examined the Claimant on September 30, 2002 and submitted an October 15, 2002 report. He summarized the findings of Claimant's prior medical records. He also outlined the Claimant's present condition, past medical history, family history, and work history. Claimant reported that he smoked for a short period during his service in the Army.

[15] According to *Stedman's Concise Medical Dictionary* (2nd Ed. 1994), a right-to-left shunt is "the passage of blood from the right side of the heart into the left (as through a septal defect), or from the pulmonary artery into the aorta (as through a patent ductus arteriosus)."

The physical examination revealed decreased breath sounds with scattered rhonci and wheezes. The cardiac exam revealed no murmurs, gallops, or rubs. The EKG revealed a normal sinus rhythm with first degree AV block. The arterial blood gas revealed a PCO2 of 31.1 and a PO2 of 59.8 at rest, and the blood gas after exercise revealed a PCO2 of 32 and PO2 of 63.4. The pulmonary function test was non-qualifying with FEV1 of 2.6, FVC of 3.91, FEV1/FVC of 66%, and MVV of 88.

Based upon all of the medical information, Dr. Rosenberg found that Claimant has interstitial lung disease, which is consistent with the diagnosis of simple coal workers' pneumoconiosis. He also stated that the Claimant has no significant obstruction or restriction but does have a decreased diffusing capacity measurement. In addition, Claimant became significantly short of breath with minimal exertion on the stress test, even though his PO2 value started to increase somewhat. He stated that Claimant may have underlying coronary artery disease. From a functional perspective, he found that Claimant does not have the respiratory capacity to perform his last coal mine job or other similarly arduous types of labor. He stated that the impairment probably relates in part to the presence of interstitial lung disease, and there is also a question of left hilar prominence which needs to be further evaluated through a CAT scan. (DX 32).

(**4) Dr. Rosenberg** submitted an addendum on April 24, 2003, after evaluating the CT scan of the Claimant taken on November 22, 2002. He stated that there was no evidence of coal worker's pneumoconiosis. He stated that he did not see any hilar mass, but cystic changes were observed throughout the lung fields, without the micronodularity[16] of coal workers' pneumoconiosis. There was no evidence of conglomerate CWP. He concluded that Claimant does not have the micronodularity of CWP, and the cystic destruction was not consistent with a CWP-related condition but rather other forms of interstitial lung disease, such as eosinophilic granuloma or sarcoidosis. He further stated that the CT scan confirmed that Claimant did not have a "coal dust related condition." (EX 2).

**(5) Gregory J. Fino, M.D.,** examined the Claimant on November 22, 2002 and prepared a report dated January 8, 2003. (EX 1). He outlined the physical condition, occupational history, present symptoms, past medical history, and family history. He reported that Claimant started smoking in 1954 and believes he stopped smoking prior to 1979. Upon examination, the lungs were reported as clear without wheezes, rales, rhonchi, or rubs. The heart sounds were also normal with no murmurs, gallops, or rubs. The chest x-ray was interpreted as negative 0/0. The spirometry revealed very mild obstruction and diffusion capacity was reduced. The arterial blood gas studies showed minimal hypoxemia. In addition, Dr. Fino reviewed the Claimant's past medical records. He also noted that a CT scan was performed at Buchanan General Hospital on the day of the evaluation which was "negative for evidence of coal worker's pneumoconiosis" and showed "granulomatous changes in the right upper zone."

The diagnosis was "Very mild obstructive lung disease and minimal hypoxemia with a reduction in the diffusion capacity." He reached the following conclusions:

[16] According to *Stedman's Concise Medical Dictionary* (2nd Ed. 1994), "micronodular" means "characterized by the presence of minute nodules; denoting a somewhat coarser appearance than that of a granular tissue or substance."

1. There is sufficient (sic) objective medical evidence to justify a diagnosis of legal pneumoconiosis.
2. There is a very mild respiratory impairment present.
3. From a respiratory standpoint, this man is neither partially nor totally disabled from returning to his last mining job or a job requiring similar effort.

(EX 1).

Factors to be considered when evaluating medical opinions include the reasoning employed by the physicians and the physicians' credentials. *See Millburn Colliery Co. v. Hicks,* 138 F.3d 524, 536 (4th Cir. 1998). A doctor's opinion that is both reasoned and documented, and is supported by objective medical tests and consistent with all the documentation in the record, is entitled to greater probative weight. *See Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (BRB 1987).

Dr. Rasmussen submitted two medical examination reports in this case, and I found both reports to be well-reasoned and documented. In the first examination report dated August 16, 2001, all conclusions were explained and supported by objective medical evidence. A supplemental report was also submitted in order to provide further explanation. However, there was one discrepancy in the report. Dr. Rasmussen stated in the first report that the cause of the diagnoses was coal mine dust exposure from 37 years of coal mine experience (apparently based upon 35 years of surface coal mine employment and two years of surface coal mine employment). In contrast, in the second examination report he indicated a total of "about 23 years" from 1953 to 1962 (approximately nine years), from 1975 to 1989 (approximately 14 years), and from 1998 to 2001 (approximately three years). The second report's findings are consistent with my finding of 26 years of coal mine employment. Dr. Rasmussen reliance upon 37 years of employment is inaccurate. Although Claimant's initial underground coal mine employment spanned a 47-year period (from 1953 to 2001), he did not perform any coal mining during the 13-year period from 1962 to 1975 or the 9-year period from 1989 to 1998. When summarizing the Claimant's coal mining history, Dr. Rasmussen apparently did not consider this hiatus in employment from 1989 to 1998 in his first examination report. It is proper to discredit a medical opinion based on an inaccurate length of coal mine employment. *Worhach v. Director, OWCP,* 17 B.L.R. 1-105 (1993) (per curiam) (physicians reported an eight year coal mine employment history, but the ALJ only found four years of such employment). Although it is proper to discredit an opinion based upon such inaccuracies, Dr. Rasmussen took into consideration other data in reaching his conclusions, as discussed above. Thus, I find that his August 16, 2001 opinion is still credible to the extent it rests on a basis outside of the length of coal mine employment. More importantly, however, Dr. Rasmussen reached essentially the same conclusions when he took into consideration an accurate history at the time of his second examination.

The second examination report by Dr. Rasmussen dated September 3, 2003 provided even more analysis. He explained how decreased single breath diffusing capacity and hypoxemia during exercise were both characteristics of coal dust related diseases. He further pointed to the progressive worsening of the Claimant's pulmonary condition, which is also a

characteristic of pneumoconiosis. I found that both reports contained good analysis to support the conclusions; however, greater weight is given to the second report inasmuch as it provides more reasoning and a comprehensive view of the Claimant's condition.

The initial report by Dr. Rosenberg was also comprehensive; however, the addendum of April 24, 2003 was not as well-reasoned as the report dated October 15, 2002. In the October 15, 2002 report, Dr. Rosenberg provided a detailed summary of Claimant's medical records. He found that Claimant has interstitial lung disease, which is consistent with a diagnosis of simple CWP, based upon the total review of the medical evidence. However, he requested that further testing, specifically a CAT (CT) scan, be conducted in order to better characterize Claimant's lung parenchyma and evaluate his left hilar fullness. He also suggested that the Claimant be evaluated for possible underlying heart disease. In an addendum dated April 24, 2003, Dr. Rosenberg changed his prior diagnosis after reviewing the CT scan. This addendum is little more than a CT scan interpretation made by a physician who is not a radiologist. In the addendum, Dr. Rosenberg stated that the scarring and destruction was not consistent with a CWP related condition but rather other forms of interstitial lung disease. Although he stated that the cystic destruction was not consistent with CWP, the report failed to explain what factors supported that conclusion. Further, although he excluded coal dust as the cause of the Claimant's interstitial lung disease, he did not address the possible contribution by other types of coal mine dust, such as silica. In this regard, the regulations specifically include silicosis as a form of clinical pneumoconiosis, and the definition of legal pneumoconiosis is much broader, including any occupationally caused dust disease of the lungs. Dr. Rosenberg also did not explain whether the Claimant may be deemed to have legal pneumoconiosis, as defined in the regulations. For such reason, I found the addendum to be lacking in analysis. Its lack of analysis is particularly troublesome as Dr. Rosenberg completely changed his opinion based upon a single piece of evidence.

Despite its inclusion of detailed findings, Dr. Fino's report also lacked in the area of analysis. Although he did not find x-ray or CT scan evidence of coal worker's pneumoconiosis, he found that there was sufficient evidence to diagnose legal pneumoconiosis. I reject the Employer's suggestion (Employer's Closing Argument at p. 11-12) that the reference to "sufficient evidence" is a typographical error. There is no statement in Dr. Fino's report that could be construed as excluding coal mine dust as a causative agent for Claimant's respiratory disability and Dr. Fino has pointed to no other etiology. Thus, his report is entirely consistent with the conclusion that there is sufficient evidence to diagnose legal pneumoconiosis, as defined above. However, Dr. Fino reached that conclusion without explaining or specifically referencing the evidence upon which he was relying. Likewise, his finding of no total or partial disability was stated with no explanation as to what objective test results supported that conclusion. Overall, the report summarized the Claimant's medical records and findings in some detail but provided minimal analysis on the issues. Dr. Fino merely stated his conclusions and failed to explain what factors supported his conclusions. Thus, the report was conclusory and is given less weight.

In weighing the medical reports, I find that the September 3, 2003 report by Dr. Rasmussen is better reasoned than the conclusory report by Dr. Fino and the conflicting report and addendum by Dr. Rosenberg. Employer argued that Dr. Rasmussen is not equally qualified

because he is not board certified in pulmonary medicine (although he is board certified in internal medicine); however, I find that all three physicians have extensive experience in the area and are equally qualified to render opinions.[17] Dr. Rasmussen practices in the area of pulmonary medicine and has extensive experience and scholarship on the subject of pneumoconiosis. Likewise, Dr. Rosenberg holds impressive credentials with board certifications in internal medicine, pulmonary disease, and occupational medicine with extensive experience in occupational diseases. Dr. Fino, too, is board certified in internal medicine and the subspecialty of pulmonary diseases and has impressive credentials. Therefore, the opinions are not distinguishable based upon the credentials of the medical doctors.

However, in comparing the content of each report I give greater weight to September 3, 2003 report submitted by Dr. Rasmussen. It is reasoned and documented, and it thoroughly explained the conclusion reached. *See Fields, supra* (stating that a "documented" opinion is one that sets forth the clinical findings, observations, facts and other data on which the physician based the diagnosis, and that a "reasoned" opinion is one in which the underlying documentation is adequate to support the physician's conclusions). In this report, he explained how the Claimant's pattern of breathing impairment and progressive worsening of the pulmonary functions were both indicators of CWP.

Moreover, the second report was more comprehensive. Dr. Rasmussen evaluated Claimant's pulmonary condition on two occasions (August 16, 2001 and September 3, 2003). The two visits provided the opportunity for him to note the progressive worsening of the Claimant's pulmonary condition, which is consistent with pneumoconiosis. *Clark v. Karst-Robbins Coal Co*., 12 B.L.R. 1-149 (1989) (en banc). Further, the Board has noted that the length of time in which the physician has treated the miner is relevant to the weight given the physician's opinion. *Revnack v. Director, OWCP,* 7 B.L.R. 1-771 (1985). I find that conducting two examinations of the Claimant assisted Dr. Rasmussen in rendering an opinion on pneumoconiosis, because he had some familiarity with Claimant's condition and was able to comment on, and compare, his condition over a two year period. Dr. Rasmussen found the worsening of Claimant's symptoms and impairment to be of significance in rendering his opinion. For the above reasons, the September 3, 2003 report by Dr. Rasmussen is entitled to the most weight.

Although greater weight was given to Dr. Rasmussen's September 3, 2003 report, it is also worth noting that all three physicians initially found that Claimant had pneumoconiosis. However, Dr. Rosenberg later changed his diagnosis to the contrary, in an addendum that I have found to lack analysis. Claimant has satisfied the burden of proving the existence of pneumoconiosis through reasoned medical opinions. Therefore, I find that Claimant has satisfied the preponderance of the evidence standard in establishing pneumoconiosis under §718.202(a)(4).

Other Evidence of Pneumoconiosis. The following evidence, consisting of CT scan interpretations and medical records, is also of record:

[17] The curricula vitae of all three physicians are in the record. (DX 32, CX 2, EX 1).

- CT Scan of November 22, 2002: April 24, 2003 interpretation by Dr. Rosenberg (EX 2) and January 8, 2003 interpretation by Dr. Fino (EX 1)

- PFT Study-St. Mary's Hospital: April 1, 1985 (DX 34)

- X-Ray Report-Southwest Virginia Community Health Services: April 1, 1985 (DX 34)

- PFT Study-Norton Community Hospital: January 2, 2001 (DX 34)

As noted above, there is no limitation on the admission of medical records or CT scan interpretations.

After reviewing all of the above records, I find that the CT scan interpretations dated January 8, 2003 (EX 1) and April 24, 2003 (EX 2) and the x-ray report dated April 1, 1985 (DX 34) are the only medical records relevant on the issue of pneumoconiosis. The PFT (pulmonary function test) records are relevant to the issue of total disability and will be discussed when I address that issue.

As stated above, Dr. Rosenberg submitted a letter regarding the CT scan taken on November 22, 2002. Dr. Rosenberg is a board certified pulmonologist, but he is not a radiologist. He stated that he did not see any hilar mass, and cystic changes were observed throughout the lung fields without the micronodularity of coal workers' pneumoconiosis. He further stated that that focal scarring observed in the right upper lung field was consistent with the x-ray findings. There was no evidence of conglomerate CWP, and he concluded that Claimant does not have the micronodularity of CWP. He stated that the cystic destruction is not consistent with CWP but is consistent with other forms of interstitial lung disease, such as eosinophilic granuloma or sarcoidosis. (EX 2). As noted above, he did not discuss the possibility of silicosis or some form of legal pneumoconiosis.

In his January 8, 2003 report, Dr. Fino stated that a CT scan performed on the day of evaluation (November 22, 2002) was "negative for evidence of coal worker's pneumoconiosis" but there were "granulomatous changes in the right upper zone." As noted above, this was one of the pieces of evidence he summarized before reaching his conclusion that the Claimant had legal pneumoconiosis. However, it is unclear whether or to what extent that piece of evidence supported his conclusion or whether he relied upon other factors.

The x-ray report taken on April 1, 1985 at Southwest Virginia Community Health Services showed that the heart was normal, and there were no acute abnormalities in the lungs. However, there were fractures noted in the right 7$^{th}$ and 8$^{th}$ ribs. I find this report is not probative of Claimant's present condition, because Claimant filed for black lung benefits on May 7, 2001 and this x-ray was taken sixteen years prior to that date. In addition, Claimant was employed in the coal mines at the time and worked for more than a decade more (from 1980 to 1989 and from 1998 to 2001) in the coal mining industry. Thus, no weight is given to this x-ray report because it is too remote in time. (DX 34).

The additional evidence, in relevant part, does not support a finding of pneumoconiosis. The CT Scan was interpreted by both Dr. Fino and Dr. Rosenberg as showing no evidence to suggest CWP. However, abnormalities suggestive of other forms of pneumoconiosis, such as sarcoidosis, were noted by Dr. Rosenberg, and Dr. Rosenberg did not discuss the possibility of silicosis or the possible contribution of other types of coal mine dust. In this regard, silica is a coal mine dust but is not a form of coal dust. Further, while Dr. Fino did not discuss silicosis either, he found the Claimant to suffer from legal pneumoconiosis in the conclusion section of his report. I find that the CT scan evidence does not support a finding that Claimant suffers from pneumoconiosis but it also does not exclude the possibility of a coal-mine-dust associated pneumoconiosis.

All Evidence on Pneumoconiosis. For the aforementioned reasons, the medical evidence does establish the presence of pneumoconiosis under §718.202(a)(4) although there is contrary evidence under the section as a whole. The regulations state that a finding of pneumoconiosis can be made on basis of either x-ray finding, biopsy or autopsy reports, presumptions described in §718.304,718.305, 718.306, or reasoned medical reports. 20 C.F.R. §718.202. Although the regulations do not require proof under all four criteria in order to establish pneumoconiosis, the Fourth Circuit has required that all of the evidence from section 718.202 be weighed together in determining whether a miner suffers from pneumoconiosis. *Island Creek Coal Co. v. Compton*, 211 F.3d 203, 208-209 (4th Cir. 2000). As this case arises in the Fourth Circuit, all of the evidence must be weighed together. Here, Claimant was able to prove the existence of the disease through the medical report evidence. However, the other evidence of record does not undermine a finding of legal pneumoconiosis and the x-ray evidence is conflicting on whether the Claimant has clinical pneumoconiosis. Taking into consideration all of the evidence on the issue of the existence of pneumoconiosis, I still find that the Claimant established that he has pneumoconiosis as defined under section 718.201.

***Causal Relationship With Coal Mine Employment***

In order for a claimant to be found eligible for benefits under the Act, it must be determined that the miner's pneumoconiosis arose at least in part out of coal mine employment. 20 C.F.R. §718.203 (a). If a miner who is suffering or suffered from pneumoconiosis was employed for ten years or more in one or more coal mines, there shall be a rebuttable presumption that the pneumoconiosis arose out of such employment. 20 C.F.R. §718.203(b). As stated above, I found that Claimant has pneumoconiosis, and he has established 26 years of coal mine employment. Thus, he is entitled to the presumption that his coal mine employment at least in part caused the disease, and this element of entitlement under §718.203 is satisfied.

Employer has pointed to other possible etiologies for the Claimant's pneumoconiosis, including his exposure to asbestos while working on truck brakes and his exposure to sand and metals when making bells at a foundry. Employer's experts have also suggested the possibility of sarcoidosis or some granulomatous disease. However, these are mere possibilities. Accordingly, I find that the presumption has not been rebutted.

***Total Disability***

The regulations as amended provide that a claimant can establish total disability by showing pneumoconiosis prevented the miner "[f]rom performing his or her usual coal mine work," and "[f]rom engaging in gainful employment in the immediate area of his or her residence requiring the skills or abilities comparable to those of any employment in a mine or mines in which he or she previously engaged with some regularity over a substantial period of time." 20 C.F.R. §718.204(b)(1). Where, as here, there is no evidence of complicated pneumoconiosis, total disability may be established by pulmonary function tests, arterial blood gas tests, evidence of cor pulmonale with right sided congestive heart failure, or physicians' reasoned medical opinions, based on medically acceptable clinical and laboratory diagnostic techniques, to the effect that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in the miner's previous coal mine employment or comparable work. 20 C.F.R. §718.204(b)(2). For a living miner's claim, it may not be established solely by the miner's testimony or statements. 20 C.F.R. §718.204(d)(5).

According to Claimant's testimony and application for benefits, he worked as a utility man shoveling around the drives and stockpiles where the coal comes out of the mine. (Tr. at 21; DX 5). He kept the coal together for pickup by the trucks. (Tr. at 21). He also swept out the bathhouse, pumped water in the tank, and answered the phone. *Id.*

Pulmonary function tests. Claimant has not established total disability through qualifying pulmonary function tests. Under subparagraph (i), total disability is established if the FEV1 value is equal to or less than the values set forth in the pertinent tables in 20 C.F.R. Part 718, Appendix B, for the miner's age, sex and height, if in addition, the tests reveal qualifying FVC or MVV values under the tables, or an FEV1/FVC ratio of less than 55%. The pulmonary function tests for the four medical examinations produced the following pre-bronchodilator (and, where pertinent, post-bronchodilator) values:

| **Date** | **Exhibit No.** | **FEV1** (pre/post) | **FVC** (pre/post) | **MVV** (pre/post) | **FEV1/FVC** (pre/post) |
|---|---|---|---|---|---|
| 08/16/2001 | DX 14 | 3.35 | 5.23 | 108 [recorded in summary as 107] | 64% |
| 09/30/2002 | DX 32 | 2.60 | 3.91 | 88 | 66% |
| 11/22/2002 | EX 1 | 2.89 | 4.48 | Not Listed | 65% |
| 09/03/2003 | CX 2 | 2.64/3.15 | 4.40/4.83 | 101/110 | 60%/65% |

None of the pulmonary function tests produced qualifying values for the Claimant's age (ranging from 72 to 74) and recorded heights (ranging from 67 inches to 71 inches). *See* 20 C.F.R. §718.204(b)(2)(i).[18] In addition, Dr. Sarah Long stated that the September 3, 2003 pulmonary function test was not valid under the Federal Black Lung Regulations. (EX 5). She

[18] Under the regulations, a male at age 71 with a height of 66.9 inches must have a FEV1 value of 1.63 in order to render qualifying values; the corresponding value for a height of 71.3 inches is 1.98. Although the Claimant's ages of 72 to 74 are not listed on the chart, the probable value for such age would be lower because the qualifying numbers decline with age. Claimant's FEV1 values are well above the qualifying values.

stated that the spirometric tracings were recorded at 5 mm/sec instead of 20 mm/sec as required by Federal Black Lung Regulations. *Id.* She further stated that the spirometric curves could not be evaluated, because they were recorded at too rapid of a speed. *Id*. However, I find that there is no need to address the reliability of this test because the results were non-qualifying and thus do not alter the outcome of the determination.

Additional pulmonary function test results appear in the hospital treatment records, from St. Mary's Hospital and Norton Community Hospital:

| **Date** | **Exhibit No.** | **FEV1** (pre/post) | **FVC** (pre/post) | **MVV** (pre/post) | **FEV1/FVC** (pre/post) |
|---|---|---|---|---|---|
| 06/11/1987 | DX 34 | 2.37/3.22 | 3.15/3.74 | 79/59 | 75%/86% |
| 01/02/2001 | DX 34 | 2.85/2.94 | 4.21/4.26 | 78/88 | 68%/69% |

These pulmonary function tests are not qualifying either, based upon the FEV1 values for the recorded ages (58 and 72) and heights (70 inches and 71 inches). However, I find the 1987 test results to be too remote in time to have any relevance to the issue of the Claimant's current disability.

Accordingly, I find that the pulmonary function tests do not support a finding of total disability under §718.204(b)(2)(i).

Arterial blood gases. Claimant has satisfied the burden of proving total disability through arterial blood gas studies under §718.204(b)(2)(ii). The four arterial blood gas studies produced the following values (rest/exercise):

| **Date** | **Exhibit No.** | **PCO2** (rest/exercise) | **PO2** (rest/exercise) |
|---|---|---|---|
| 8/16/01 | DX 12 | 25/29 | 52/55 |
| 9/30/02 | DX 32 | 31.1/32.6 | 59.8/63.4 |
| 11/22/02 | EX 1 | 29.9 | 69.1 |
| 9/3/03 | CX 2 | 29/31 | 53/57 |

All of the above results produced qualifying values under the regulatory standards set forth in 20 C.F.R. Part 718, Appendix C. Employer argued that the August 16, 2001 and September 3, 2003 studies produced increased values during exercise.[19] However, it is worth noting that these increased values still were below the disability standards. Thus, I find that Claimant has satisfied section 718.204(b)(2)(ii).

Cor pulmonale with right-sided congestive heart failure. There is no evidence of cor pulmonale or congestive heart failure, so Claimant has not established total disability under section 718.204(b)(2)(iii).

[19] Although the exercise oxygen values were lower than the resting values, Dr. Rasmussen explained how the oxygen values declined from the treadmill baseline (as discussed in footnote 18 below and accompanying test).

Medical opinion evidence on total disability. I also find that Claimant has established total disability through reasoned medical reports. The following physicians provided medical opinions addressing the issue of whether Claimant is totally disabled due to pneumoconiosis:

- Dr. Rasmussen, who conducted the Department of Labor examination on August 16, 2001 and an examination on behalf of Claimant on September 3, 2003;
- Dr. Rosenberg, who examined the Claimant on behalf of the Employer on September 30, 2002;
- Dr. Fino, who examined the Claimant on behalf of the Employer on November 22, 2002.

As noted above, I have found all three physicians to be equally qualified to express opinions on the Claimant's lung condition and its etiology, and I further find them to be equally qualified to express opinions on the degree of his pulmonary or respiratory impairment.

All of the medical reports were summarized under the discussion of pneumoconiosis, and thus I will proceed by considering each report as it relates to the issue of total disability.

Dr. Rasmussen found total disability based upon the marked loss of lung function revealed in the arterial blood gas studies. Claimant's baseline blood gases were PCO2 of 28 and PO2 of 59, and after seven minutes of exercise the PCO2 was 29 and PO2 was 55.[20] He concluded that Claimant does not retain the capacity to perform his last coal mining job. In this regard, he discussed in detail the work that the Claimant performed as an outside man, which involved "considerable heavy and some very heavy" manual labor. Although the lifting requirements of the job as described by Claimant to Dr. Rasmussen were somewhat higher than the daily lifting requirements he reported on the employment form (DX 5), involving occasional lifting of up to 40 pounds, I have no reason to question that account. Dr. Rasmussen's report thoroughly explained his finding of total disability and was supported by objective data.

Dr. Rosenberg also found total disability in his medical report. He based his finding on the Claimant's decreased diffusing capacity and the significant worsening of Claimant's shortness of breath during the stress test. He concluded that from a functional perspective, Claimant could not perform his previous coal mine job or other similarly arduous types of labor. Similarly, I find that the initial report of Dr. Rosenberg contains sufficient reasoning and is supported by objective medical evidence. Further, Dr. Rosenberg's conclusions in his initial report on the Claimant's total disability is not undermined in any way by the conclusory addendum, in that the addendum does not discuss the total disability issue.

However, the report of Dr. Fino was not persuasive on the total disability issue. Dr. Fino's finding, that the Claimant was neither totally nor partially disabled from a respiratory standpoint from returning to his last mining job or a job requiring similar effort, was conclusory and contained no reasoning. He failed to identify the basis for such conclusion or reference any

[20] The respective values taken during the exercise test for PCO2 and PO2 were 28/59 baseline (1.7 min., heart rate 90), 29/58 exercise (6.7 min., heart rate 104), 29/55 exercise (9.2 min., heart rate 113), and 30/67 recovery (12.2 min., heart rate 101) (DX 14). The exercise portion apparently began two or three minutes into the test so the last of the two exercise readings was taken after approximately 7 minutes of exercise, as Dr. Rasmussen indicated. *Id.*

objective test which he was relying upon in reaching the conclusion. In his report, Dr. Fino noted the findings of very mild obstruction on spirometry, reduced diffusing capacity, and minimal hypoxemia; he listed the Claimant's complaints of worsening shortness of breath and exercise-induced dyspnea; and he summarized the testing results including the consistently qualifying ABGs. However, he did not explain what impact those findings would have on the Claimant's ability to perform his last coal mine job, which Claimant told him included "very occasional heavy labor." For this reason, Dr. Fino's opinion on total disability is given little weight.

Overall, more weight is given to the medical reports of Drs. Rasmussen and Rosenberg concerning the issue of total disability. Both physicians found that Claimant was totally disabled from a pulmonary or respiratory standpoint, and thus I find that Claimant has proven total disability through medical opinion evidence under §718.204(b)(2)(iv).

Other evidence. The only other evidence consists of the pulmonary function tests in the medical records, which are discussed above, along with the other pulmonary function test results.

Section 718.204(b)(2) as a whole. Looking at §718.204(b)(2) as a whole, I find that total disability has been established through arterial blood gas studies and medical opinions despite the non-qualifying pulmonary function tests. In so finding, I rely upon the opinions of Drs. Rasmussen and Rosenberg.

***Total Disability Causation***

After establishing that a miner was totally disabled, a claimant must still establish that the miner's total disability was caused by his or her coal mine employment. 20 C.F.R. §718.24(a). If the presumptions are not available to a claimant, that claimant must prove the etiology of the disability by a preponderance of the evidence, even if he or she has proven the existence of total disability. *See Tucker v. Director*, 10 B.L.R. 1-35, 1-41 (1987). Under the amended regulations, the finder-of-fact must not take into account any non-pulmonary or non-respiratory impairments a miner may have when making this determination, unless said condition causes a chronic respiratory or pulmonary impairment. 20 C.F.R. §718.204(a). In meeting this last requirement, a claimant must show that "pneumoconiosis. . . is a substantially contributing cause of the miner's totally disabling respiratory or pulmonary impairment," which means that it had a material adverse effect on the miner's respiratory or pulmonary condition or that it materially worsened a totally disabling respiratory or pulmonary impairment caused by a disease or exposure unrelated to coal mine employment. 20 C.F.R. §718.204(c)(1). The new regulations allow for a finding of total disability due to pneumoconiosis even when there is another totally disabling respiratory or pulmonary condition if pneumoconiosis has a material adverse effect or materially worsens an unrelated total respiratory or pulmonary disability. *See* 20 C.F.R. §204 (2001). *See also Tennessee Consolidated Coal Co. v. Director, OWCP [Kirk]*, 264 F.3d 602 (6th Cir. 2001).

Medical opinions regarding causation of total disability were offered in connection with the instant claim by Drs. Rasmussen and Rosenberg; Dr. Fino's report contained no discussion on disability causation, because he did not find total disability in this case. Dr. Fino also did not

address the issue of the cause of such impairment as he did find. However, he did not in any way exclude coal mine dust as a possible causative agent. His finding of legal pneumoconiosis is entirely consistent with a determination that the Claimant's impairment was due in whole or in part to his employment in coal mining.

Dr. Rasmussen stated in his August 16, 2001 report that it was medically reasonable to conclude that Claimant's CWP arose from his coal mine employment. (DX 11). He stated that although the possibility of a resting right to left shunt is not entirely excluded, his coal mine dust exposure remained the only known cause of Claimant's impairment. *Id*. His later report dated September 3, 2003 clarified the issue of disability causation. He stated that the marked impairment in oxygen transfer and the progressive worsening of the Claimant's pulmonary functions (based upon degree of impairment per unit of oxygen consumption) further supported his determination that the disability was the effect of coal mine dust exposure. (CX 2). Dr. Rasmussen again stated that the possibility of a right to left shunt "associated with pulmonary hypertension" was not excluded.[21] As noted above (footnote 14), a right-to-left shunt is, by definition the passage of blood from the right side of the heart into the left or from the pulmonary artery into the aorta. It is unclear why Dr. Rasmussen mentioned this possibility. However, it is unnecessary that every possible cause be excluded. As a whole, Dr. Rasmussen's report supports a finding that the most likely cause of Claimant's total disability is his exposure to coal mine dust.

Initially, Dr. Rosenberg found that interstitial lung disease was the cause of the Claimant's disability and that the interstitial lung disease was consistent with simple CWP (coal worker's pneumoconiosis); however after reviewing the CT scan he prepared an addendum in which he concluded that there was no evidence of CWP . (DX 32, EX 2). In that addendum, he found that Claimant had another form of interstitial lung disease, which is non-coal dust related. *Id.* As amended by the addendum, however, Dr. Rosenberg's opinion still stands for the proposition that the Claimant's disability was caused by his interstitial lung disease. What has changed is his opinion that the interstitial lung disease was caused by coal mine employment, a conclusion that I have addressed (and rejected) above.

In considering the medical opinions on disability causation, the report of Dr. Rasmussen is given the most weight. His discussion explained what factors supported his conclusion that the Claimant's disability was caused by coal dust exposure. Dr. Rosenberg's report failed to adequately explain the basis for his changed diagnosis and his conclusion that Claimant had a non-coal dust related form of interstitial lung disease rather than coal worker's pneumoconiosis and, for the reasons discussed above, I have rejected that conclusion. Moreover, Dr. Rosenberg did not change his determination that the Claimant's disability was caused by his interstitial lung disease, whatever may have been the cause of that disease. As noted above, Dr. Fino did not find total disability or address the cause of such impairment as he did find. Therefore, I find that Claimant has proven by a preponderance of the evidence that pneumoconiosis was a substantially contributing factor to the Claimant's total disability.

[21] Dr. Rasmussen recorded a blood pressure of 122/82 at the time of his September 3, 2003 examination and a blood pressure of 110/90 at the time of the August 16, 2001 examination. (CX 2; DX 11). He did not explain the reference to pulmonary hypertension in his latter report.

***Conclusion***

Claimant has proven all four elements of entitlement, which are the existence of pneumoconiosis, its causal relationship with coal mine employment, total disability, and causation of disability through the evidence admitted. Thus, having established all of the requisite elements of entitlement under the Act and regulations by a preponderance of the evidence, Claimant is entitled to the award of benefits. The parties have agreed that there is one dependent (Claimant's wife) for augmentation purposes.

**Onset Date**

Under 20 C.F.R. §725.503(b), the date of commencement of benefits is "the month of onset of total disability." However, "where the evidence does not establish the month of onset, benefits shall be payable to such miner beginning with the month during which the claim was filed." *Id*. Here, Claimant stopped working in the coal mines on August 31, 2001, and was apparently able to satisfactorily perform his job (albeit with some difficulty after his bouts with pneumonia) prior to that time. According to testimony he provided at his July 22, 2002 deposition, he was offered the opportunity to come back to work when the mine reopened two to three months before (i.e., April to May 2002), but he was unable to do so because of his breathing. (DX 31 at p. 18). At the hearing, Claimant testified that it was not until he got pneumonia (on two occasions in 2001), when he was still employed in the mines, that his breathing declined so much that he had difficulty performing his job. (CX 2; Tr. at 20). It is clear that the Claimant became totally disabled some time in 2001 or early 2002, but it is unclear when. His ABGs were qualifying as early as August 16, 2001, when he was first examined by Dr. Rasmussen and was still employed; however, he left coal mining at the end of that month. None of the medical evidence or testimony offered in connection with this claim conclusively establishes the precise date that Claimant became totally disabled due to pneumoconiosis, which would result in benefits commencing as of May 2001, the date Claimant filed the subsequent claim for benefits. However, a claimant is not entitled to benefits if he continues to work after a final determination of entitlement or if he returns to work after having been finally determined to be entitled to benefits. 20 C.F.R. §725.504 (2001). It is, however, unclear whether the Claimant may receive benefits for the period that he was employed as a miner, from May 2001 until August 31, 2001, inasmuch as a final determination has not been issued.

In *Amax Coal Co. v. Director, OWCP [Chubb]*, 312 F.3d 882 (7th Cir. 2002), the Court of Appeals for the Seventh Circuit held that the date of onset for the payment of benefits was not the date on which the miner retired from working in the coal mines but, under 20 C.F.R. §725.503, if the date of onset cannot be determined from the medical evidence, then it is the date on which the miner filed his claim. In that case, the miner terminated his employment in August 1978 but returned to coal mine work in September 1981 for a period of one year. Pursuant to 20 C.F.R. §725.504 (2001) (formerly 20 C.F.R. §725.503A), the court determined that the payment of benefits would be suspended for that period of time.

Accordingly, I find that benefits are payable beginning on September 1, 2001, rather than August 1, 2001, as found by the district director. In this regard, benefits will commence on May

1, 2001 under §725.503, but will be suspended for the period from May 1, 2001 until August 31, 2001 under §725.504, due to the Claimant's employment during that period.

**Reimbursement of Trust Fund**

The Employer shall reimburse the Trust Fund for payments already made to the Claimant and shall receive a full credit for payments made. In view of my holding that benefits shall commence on September 1, 2001, instead of August 1, 2001, the Claimant's entitlement to benefits will be reduced by the amount paid for the month of August 2001.

**Attorney's Fee**

No award of attorney's fees is made herein, because no fee application has been received. *See* 30 U.S.C. §932; 33 U.S.C. §928. The Claimant's attorney shall have thirty days for submission of a fee application in conformance with 20 C.F.R. Part 725 and the other parties shall have thirty days to file any objections, provided that these dates may be extended upon the stipulation of the parties or for good cause shown.

## ORDER

**IT IS HEREBY ORDERED** that the claim of Curtis Kiser for black lung benefits be, and hereby is, **GRANTED** and L & J Equipment Company shall commence payment of benefits with an effective date of September 1, 2001, with one augmentee, and shall reimburse the Trust Fund for payments made to the Claimant, receiving a credit for payments so made.

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PAMELA LAKES WOOD
Administrative Law Judge

Washington, D.C.

**NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. §725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within thirty (30) days from the date of this Decision by filing a Notice of Appeal with the Benefits Review Board at P.O. Box 37601, Washington, D.C. 20013-7601. A copy of this Notice of Appeal must also be served on Donald S. Shire, Associate Solicitor for Black Lung Benefits, 200 Constitution Avenue, N.W., Room N-2117, Washington, D.C. 20210.**